STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155305	A. BUILDING _____ B. WING _____	03/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKILLED CARING CENTER OF MEMORIAL HOSPITAL	800 W NINTH STREET JASPER, IN47546

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: March 22, 23, 24, 2011 Facility Number: 000202 Provider Number: 155305 Aim Number: 100284870 Survey Team: Brenda Buroker, RN TC Debora Barth, RN Donna Downs, RN Lois Corbin, RN Census Bed Type: SNF/NF: 13 Total: 13 Census Payor Type: Medicare: 12 Other: 1 Total: 13 Stage 2 Sample: 16 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed 3-28-11 Cathy Emswiller RN	F0000	Credible Allegation of compliance and correction:Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facilities allegation of compliance in accordance with section 7305 of the State Operations Manual.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0156 SS=A	Based on interview and record review, the facility failed to ensure notification for non-coverage of Medicare services was provided two days prior to the end of services for one of one Medicare beneficiaries discharged in the last 6 months who was reviewed for required discharge from skilled service information. The facility also failed to include the name and phone number of the Quality Improvement Organization on the notice of Medicare provider non-coverage. (Resident #34) Findings include: The closed clinical record of Resident #34 was reviewed on 3/23/11 at 10:00 a.m. The resident's record included a copy of the "Notice of Medicare Provider Non-Coverage" (OMB Approval No. 0938-0953) signed by the resident's representative and the Social Worker on 11/18/2010. The notice indicated the resident's effective date of coverage of skilled nursing services would end on 11/18/10. The notice did not include the name and number of the Quality Improvement Organization in the event the resident and/or representative wished to appeal the decision.	F0156	1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Facility policy for "Notification of Medicare Denial of Covered Services in the Skilled Caring Center and Financial Responsibility" was revised on 3/24/11 at 10:30am. **See Exhibit A.** The policy revision states "… Notification of the determination of non-covered status is given at least two business days prior to the resident's termination of services." The "Notice of Medicare Provider Non-Coverage" form (OMB approval No. 0938-0953) was revised on 3/24/11 at 11:15am. **See Exhibit B**. The form revision includes under "How to ask for an immediate appeal Bullet # 4", the name and number of the Quality Improvement Organization in the event the resident and/or representative wished to appeal the decision. The revised form states "...Call your QIO at: 800-288-1499 (Health Care Excel) to appeal, or if you have questions." Facility contacted Health Care Excel facilities manager and they stated they do not have a TTY number to include on our form. The Medicare TTY number is included on the form. On 3/24/11 at 11:30am, Social Worker and Director of Nursing educated on the revised policy and form and instructed to begin utilizing immediately as warranted	04/23/2011

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	The current policy for "Notification of Medicare Denial of Covered Services in Skilled Caring Center and Financial Responsibility," dated 3/10, was provided by the Administrator on 3/23/11 at 3:05 p.m. and indicated the following: "Purpose: To provide a method for giving written notice to a Medicare patient and his or her guarantor when a non-covered decision is made. . . B. Resident is covered at time of admission but becomes non-covered during continued stay. Administrative Denial Decision. When the Skilled Caring Center's Director of Nursing, or Skilled caring Center's Administrator determines that the resident ' s condition and medical treatment no longer meet the 'Medicare Guidelines for Covered Care', a non-covered letter is issued. . .Notification of the determination of non-covered status is given one business day prior to the resident ' s financial responsibility date. . ." The form instructions for the Notice of		for residents. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Resident # 34 was the only resident who no longer met the "Medicare Guidelines for Covered Care" which warranted notification of "Medicare Denial of Covered Services" as of 04/07/11. No other residents have required notification as of 04/07/11. Facility policy for "Notification of Medicare Denial of Covered Services in the Skilled Caring Center and Financial Responsibility" was revised on 3/24/11 at 10:30am. **See Exhibit A.** The policy revision states "… Notification of the determination of non-covered status is given at least <u>two</u> business days prior to the resident's termination of services." The "Notice of Medicare Provider Non-Coverage" form (OMB approval No. 0938-0953) was revised on 3/24/11 at 11:15am. **See Exhibit B**. The form revision includes under "how to ask for an immediate appeal Bullet # 4", the name and number of the Quality Improvement Organization in the event the resident and/or representative wished to appeal the decision. The revised form states "...Call your QIO at:	

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	Medicare Provider Non-Coverage, obtained from cms.gov on 3/23/11 at 8:00 p.m., included, but was not limited to, the following: "A Medicare provider must give a completed copy of this notice to beneficiaries receiving services from skilled nursing facilities (SNFs), home health agencies (HHAs), comprehensive outpatient rehabilitation facilities (CORFs), or hospice not later than 2 days before the termination of services. This notice fulfills the requirement at 42 CFR 405.1200(b)." "How to ask for an immediate appeal Bullet # 4 Insert the name and telephone numbers (including TTY) of the applicable QIO in no less than 12-point type." During interview with the Administrator on 3/24/11 at 8:10 a.m., she indicated they had issued the Notification of Medicare Denial of Covered Services to Resident #34 on the date of non-covered status, and their current policy indicated one business day was required. 3.1-4(f)(3)		800-288-1499 (Health Care Excel) to appeal, or if you have questions." On 3/24/11 at 11:30am, Social Worker and Director of Nursing educated on the revised policy and form and instructed to begin utilizing immediately as warranted for residents. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Revised and instituted the following policy. "Notification of Medicare Denial of Covered Services in Skilled Caring Center and Financial Responsibility". **See Exhibit A.** Revised and instituted the "Notice of Medicare Provider Non-Coverage" form (OMB approval No. 0938-0953) was revised on 3/24/11 at 11:15am. **See Exhibit B**. On 3/24/11 at 11:30am, Social Worker and Director of Nursing educated by the Administrator on the revised policy and form and instructed to begin utilizing immediately as warranted for residents. 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Health Information Representative will review all Medicare Denials that are given to residents as warranted to	

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			ensure 2 days notice has been given as written in policy and the "Notice of Medicare Provider Non-coverage" form has the QIO information included. Monitoring will be on-going.	

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F0329 SS=D	Based on interview and record review the facility failed to ensure psychoactive drugs were only given after other interventions had been attempted in an effort to avoid unnecessary drugs for 2 of 2 residents reviewed who met the criteria for psychoactive drugs in a sample of 13. [Residents #125 and 130] Findings include: **1. The clinical record for Resident #125 was reviewed on 3/23/11 at 10:53 A.M. and indicated the resident was admitted to the facility on 3/18/11. The physician orders on admission included Lorazepam [also know as Ativan, an antianxiety medication] 2 mg HS prn [2 milligrams at bedtime as needed.]** The electronic medication record system indicated the resident had been administered the medication on 3/21/11 at 10:53 P.M. and 3/21/11 at 2:10 A.M. A nurses note on 3/21/11 at 5:19 A.M. indicated the Lorazepam had been given for sleep and the resident "has not slept since adm [administration of	F0329	Describe what the facility did to correct the deficient practice for each client cited in the deficiency. On 3/24/11 a draft policy was initiated for Utilization of Psychotropic medications. At 4:45pm educational information was sent to the Skilled Caring Center's nurses via e-mail to address the utilization of psychoactive medications. Emphasis was placed on providing alternative interventions prior to the administration of any psychotropic medication and the method to document this in the medical record.On 3/24/11 at 5:00pm, all resident's with physician orders for psychotropic medications were reviewed by the Director of Nursing for clinical justification of these medications.On 3/28/11 a new policy for Psychotropic Utilization was developed and initiated. The new policy was posted for all staff to review. **See Exhibit C** 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. On 3/24/11 a draft policy was initiated for Utilization of Psychotropic medications. At 4:45pm educational information was sent to the Skilled Caring Center's nurses via e-mail to address the utilization of	04/23/2011

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	ativan]." There was an entry by the nurse who administered the 3/21/11 Lorazepam that before the drug was given the resident was repositioned. There was no indication what other interventions had been attempted to help the resident with insomnia before giving the drug on 3/23/11. Interview with the DoN on 3/24/11 at 9:30 A.M. indicated the electronic record system had a screen for the nurses to document what other interventions were attempted prior to administering a psychoactive drug. She provided the screen for review. The nurse had only checked the box indicating the resident was medicated as ordered and not checked any other intervention for the medication dates of 3/21/11 and 3/23/11. 2. The clinical record for Resident #130 was reviewed on 3/23/11 at 11:30 A.M. and indicated Xanax [an antianxiety medication] and Ambien [a sleeping medication] were ordered on admission on 3/17/11. The clinical record indicated on 3/18/11, Xanax 0.25 mg was given at		psychoactive medications. Emphasis was placed on providing alternative interventions prior to the administration of any psychotropic medication and the method to document this in the medical record.On 3/24/11 at 5:00pm, all resident's with physician orders for psychotropic medications were reviewed by the Director of Nursing for clinical justification of these medications.On 3/28/11 a new policy for Psychotropic Utilization was developed and initiated. The new policy was posted for all staff to review. **See Exhibit C** 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. On 3/28/11 a new policy for Psychotropic Utilization was developed and initiated. The new policy was posted for all staff to review. **See Exhibit C** On 4/1/11 educational flyer was sent to all staff via email and was posted in the conference room and at the nurse's station. **See Exhibit D** Beginning 4/18/11, residents admitted with orders for psychotropic medications will be provided education regarding type of medication, indications of usage, most common potential side effects and rationale for attempting alternative	

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	1:22 A.M. for anxiety. On 3/22/11 at 4:00 A.M. Xanax 0.25 mg was given for insomnia. Ambien had been given 3/21/11 and 3/22/11. According to the documentation in the electronic record, on 3/18/11 at 1:22 A.M., the resident exhibited anxiety, and the medication was given. The record indicated the other intervention used was "position change." During interview with the DoN at 9:13 A.M. on 3/24/11, she indicated she reviewed the care plan for the resident. She located documentation in the electronic record related to the two dates the resident was given the Xanax and there was a place for the nurse to check other interventions tried prior to giving the drug. The only intervention checked was"medicate as ordered." During the interview, the DoN indicated the Ambien was ordered routinely and not as a prn, or as needed, drug. She was unable to indicate what the facility policy was regarding administering routine hypnotic drugs. Interview with the DoN and Administrator on 3/24/11 at 9:30 A.M. indicated the only policy the facility had for psychoactive drugs was the		interventions. Nurses are being educated on new procedure prior to their next assigned shift. **See Exhibit E** The Director of Nurses will provide additional in-service/education training during annual competencies for all Skilled Caring Center nurses that are scheduled 4/11/11, 4/19/11, 4/20/11 and 4/22/11. Information will include review of current policies entitled Freedom from Unnecessary Drugs, **See Exhibit F**; Use of Antipsychotic Drugs, **See Exhibit G**, and the new policy on Psychotropic Utilization.On 4/18/11 the Health Information representative will begin utilizing a work sheet during the admission chart review to address potential unnecessary medications. **See Exhibit H** This information will be relayed to the nurses. Nurses will be responsible to verify the justification of all psychotropic medications prescribed.On 4/26/11 an updated Health Care Plan Conference Summary form to be implemented that addresses the use of psychotropic medications. **See Exhibit I** 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The consultant pharmacist will complete monthly reviews to address psychotropic medications as well as for	

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	one for psychotropic drug use and a policy for chemical restraint. Neither of the policies indicated a procedure to ensure antianxiety and hypnotic drugs were given only after other interventions had been tried and with adequate indication for their use. 3.1-48(a)(4)		unnecessary medications. A log of recommendations will be kept. A report of the findings will be reported to the Administrator.The Administrator will monitor compliance on an ongoing basis and either the Administrator or the Consulting Pharmacist will report findings at the quarterly Quality Assessment/ Performance Improvement committee. Committee members will monitor overall effectiveness and make recommendations as needed.The Director of Nurses will conduct monthly random monitoring of psychotropic alternative documentation to ensure nurses are offering alternative interventions prior to administration of any psychotropic medications. Monitoring will be 5 random times a month for 2 months, then 2 times a month for 4 months then be re-evaluated at the quarterly Quality Assessment/ Performance Improvement comm ittee. See Exhibit J	

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F0441 SS=E	Based on observation, interview, and record review, the facility failed to ensure residents were free of possible cross contamination between glucometer use for 5 of 13 residents who were diabetic and received accuchecks for glucose monitoring (Resident #21, #122, #126, #127, and #129). Findings include: On 3/24/11 at 8:15 a.m., during observation of 1 of 1 medication room, two glucometers were noted. The DoN (Director of Nurses) indicated at this	F0441	**1.Describe what the facility did to correct the deficient practice for each client cited in the deficiency.** On 3/24/11 the facility received a list of approved disinfectants from the manufacturer (Roche) of the Accu-chek machines. The PDI Super Sani-cloth was approved to use to clean AND disinfect the machines. The facility checked the FDA website and the ingredients in the PDI Super Sani-cloths are recommended for disinfecting. (FAQ on PDI Super Sani-cloth and a fax from Roche on acceptable active disinfecting solutions to use on the Accu-chek inform system). (**See Exhibit K and L)** The facility had the PDI Super Sani-cloths in stock and prior to the next set of Accu-cheks that were performed. On 3/24/11 at 3:30 pm all Accu-chek machines were disinfected with PDI Super Sani cloths. The two Accu-chek machines that are used in the facility were disinfected with the PDI Super Sani-Cloths between each remaining resident (Resident #122, #126, #127 and #129) (Resident #21 was discharged therefore was no longer an issue.) who required glucose monitoring. The Administrator and Director of Nursing began educating all nurses on 03/24/11 at 3:30pm. (**See Exhibit M)** In addition, a memo regarding the change in procedure regarding the disinfecting of	04/23/2011

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	time, "the glucometers were used for all residents. For cleaning, the nurses use alcohol swabs to clean the glucometer between each patient." On 3/24/11 at 8:30 a.m. during an interview with the Infection Control Nurse (RN #2), she indicated they have several glucometers in the lab that could be used. She was not familiar with any guidance from the CDC (Centers for Disease Control) regarding the recommendation to not use alcohol singly as a		Accu-chek machines was posted on the med room door; area where machines are kept; conference room and via email to all staff. On 3/25/11, our infection control nurse sent out a notice to the rest of the hospital and the “Equipment Cleaning and High Touch Cleaning” policy was revised to address the use of PDI Super Sani-cloths to clean and disinfect the Accu-chek Machines. On 4/1/11, the “Accu-chek Glucose Testing” policy **(See Exhibit N)** was revised to refer to the “Equipment Cleaning and High Touch Cleaning” policy **(See Exhibit O)** for cleaning the machines also. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. On 3/24/11 the facility received a list of approved disinfectants from the manufacturer (Roche) of the Accu-chek machines. The PDI Super Sani-cloth was approved to use to clean AND disinfect the machines. The facility checked the FDA website and the ingredients in the PDI Super Sani-cloths are recommended for disinfecting. (FAQ on PDI Super Sani-cloth and a fax from Roche on acceptable active disinfecting solutions to use on the Accu-chek	

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	cleaning agent for glucometers. A current policy and procedure, originally dated 6/09 with review and revision 2/10, was provided by RN #2 on 3/24/11 at 8:30 a.m. The policy was titled "Equipment Cleaning and High Touch Cleaning" and indicated the following: "Policy: Medical devices that come in contact with intact skin but not mucous membranes need cleaning and low level disinfection. Disinfectant should be Environmental Protection		inform system). (**See Exhibit K and L**) The facility had the PDI Super Sani-cloths in stock and prior to the next set of Accu-cheks that were performed on 3/24/11 at 3:30pm, all Accu-chek machines were disinfected with PDI Super Sani-cloths. The two Accu-chek machines that are used in the facility were disinfected with the PDI Super Sani-cloths between each remaining resident (Resident #122, #126, #127 and #129) (Resident # 21 was discharged) who required glucose monitoring. The Administrator and Director of Nursing began educating all nurses on 03/24/11 at 3:30pm. (**See Exhibit M)** In addition, a memo regarding the change in procedure regarding the disinfecting of Accu-chek machines was posted on the med room door; area where machines are kept; conference room and via email to all staff. On 3/25/11, our infection control nurse sent out notice to the rest of the hospital and the "Equipment Cleaning and High Touch Cleaning" policy was revised to address the use of PDI Super Sani-cloths to clean and disinfect the Accu-chek Machines. The "Accu-chek Glucose Testing" policy **(See Exhibit N)** was revised to refer to the "Equipment Cleaning and High Touch Cleaning" policy **(See**	

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	Agency (EPA) registered... Isopropyl alcohol 70% (alcohol pads) Hydrochloride (Bleach wipes) Quaternary ammonium germicidal detergent solution (Quat 256) Amerse (Only in certain situation, as listed)Procedure: Equipment Cleaning: Equipment shared between patients needs to be cleaned after each use to reduce transmission of organisms. . . Check list for suggested cleaning product for equipment. . ."		**Exhibit O)** for cleaning the machines also. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.Revised and instituted the following policies: “Accu-chek Glucose Testing” policy **(See Exhibit N)** and the “Equipment Cleaning and High Touch Cleaning” policy **(See Exhibit O)**Explanation and demonstration was provided to nurses; memo regarding the change in procedure regarding the disinfecting of Accu-chek machines was posted on the med room door; area where machines are kept; conference room and via email to all staff.The Director of Nurses will reinforce information during annual competencies for all Skilled Caring Center nurses that are scheduled 4/11/11, 4/19/11, 4/20/11 and 4/22/11. 4.Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.Infection control nurse will be responsible to have appropriate disinfectant available for staff to use to disinfect Accu-chek machines against pathogenic agents.The Director of Nurses will conduct monthly	

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	155305	A. BUILDING _____ B. WING _____	03/24/2011

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	At 8:50 a.m. on 3/24/11, a document was provided by the DoN regarding manufacturer recommendations for Accu check [facility's glucometer name]. The document was titled "ACCU -CHECK Inform System Operator's Manual How to Clean the System. Wipe the surfaces with a soft cloth slightly dampened (NOT WET). Dry the meter and the base unit thoroughly after cleaning...You may also wipe the surfaces with a soft cloth slightly dampened (NOT WET)		random monitoring of nurses performing glucose testing to ensure nurses are disinfecting Accu-chek machines with proper disinfectant prior to patient use and following revised policy. Monitoring will be 5 random times a month for 2 months, then 2 times a month for 4 months then be re-evaluated at the quarterly Quality Assessment/ Performance Improvement committee. **See Exhibit P**	

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	with 70% isopropyl alcohol, full strength. . . Warning: Do not use cleaners containing the chemicals ether, polyhexanide, phenol, or prepared solus or wipes contain ga mixture of bleach and detergent on the ACCU-CHEK Inform meter. Use of cleaners containing these chemicals could result in damage to the ACCU-CHEK inform meter. . . Acceptable active ingredients are: water, soap, 70% (or less) isopropyl alcohol, 1:10 dilution of sodium hypochlorite, ammonium chloride (quaternary			

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	ammonium compounds)..." On 3/24/11 at 9:05 a.m. during an interview with RN #1, she indicated the two glucometers in the medication room were the ones used for residents. She indicated she currently had two residents who got accuchecks at 7 a.m. and 4 p.m. She was also aware of another resident who received accuchecks four times per day. She indicated the nurses clean the glucometers with alcohol swabs inbetween each resident use and			

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demonstrated how it was done using an alcohol wipe and cleaned the outside only.

On 3/24/11 at 10:00 a.m. the DoN provided a listing of residents who received accuchecks. There were 5 current residents in the facility (Resident #21, #122, #126, #127, and #129) who were diabetic and received glucose monitoring.

The Administratior indicatied during intierview on 3/24/11 ati10:30 A.M. she had received an email from tihe manufactiurer of tihe glucometier. The email indicatied

"Alcohol is listied in our manual buti tihe question comes in when disinfecting tihe metier. You would need sometihing otiher tihan alcohol We leave iti tio tihe hospitial tio

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	creatie tiheir own cleaning policy' 3.1-18(b)(1)			